LOUDOUN ENDODONTICS

Matthew S. Detar, DDS, MSD
Diplomate, American Board of Endodontics
Frederick L. Canby, DDS, MS
Preeti Batra, BDS, MSD

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE)			SEX	DOB
MAILING ADDRESS	CITY	STATE	ZIP	SSN
STREET ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP	HOME PHONE NUMBER
EMPLOYER				CELL PHONE NUMBER
WORK ADDRESS	CITY	STATE	ZIP	WORK PHONE NUMBER
GENERAL DENTIST NAME	HOW WERE YOU REFFERED TO OUR OFFICE (IF OTHER THAN YOUR GENERAL DDS)?			

SPOUSE or GUARDIAN INFORMATION

RELATIONSHIP				
NAME (LAST, FIRST, MIDDLE)			SEX	DOB
MAILING ADDRESS	CITY	STATE	ZIP	SSN
STREET ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP	HOME PHONE NUMBER
EMPLOYER				CELL PHONE NUMBER
WORK ADDRESS	CITY	STATE	ZIP	WORK PHONE NUMBER

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE			PHONE NUMBER	
NAME OF POLICY HOLDER OR SUBSCRIBER				
SUBSCRIBER ID NUMBER				GROUP NUMBER
MAILING ADDRESS FOR DENTAL CLAIMS	CITY	STATE	ZIP	

EMERGENCY CONTACT INFORMATION

RELATIVE NOT LIVING WITH YOU TO CONTACT IN CASE OF EMERGENCY				
RELATIONSHIP			PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP	

MEDICAL PHYSICIAN INFORMATION

PHYSICIAN NAME (LAST, FIRST, MIDDLE)	OFFICE PHONE NUMBER	DATE OF LAST EXAM

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	YES	NO
1. Are you under medical treatment now?		
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?		
If yes, please explain: _____		
3. Are you taking any medication(s) including non-prescription medicine?		
If yes, what medication(s) are you taking? _____		
4. Do you use tobacco?		
5. Do you use controlled substances?		
6. Are you wearing contact lenses?		

7. Are you allergic or have you had any reactions to the following:

	YES	NO		YES	NO
Local Anesthetics (e.g. Lidocaine)			Barbiturates		
Penicillin or any other Antibiotics			Sedatives		
Sulfa Drugs			Iodine		
Any Metals (e.g. Nickel, Mercury, etc.)			Aspirin		
Latex Rubber			Other (Please List):		

8. Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure			Respiratory Problems			Rheumatic Fever		
Low Blood Pressure			Emphysema			Tuberculosis		
Heart Attack			Swollen Ankles			Stroke		
Heart Disease			Fainting/Seizures			Cancer		
Cardiac Pacemaker			Asthma			Leukemia		
Heart Murmur			Hay Fever/Season Allergies			Radiation Therapy		
Angina			Stomach Troubles/Ulcers			Glaucoma		
Mitral Valve Prolapse			Joint Replacement/Implant			Recent Weight Loss		
Chest Pains			Thyroid Problem			Frequently Tired		
Epilepsy/Convulsions			Arthritis			Anemia		
Diabetes			Hepatitis/Jaundice			Easily Winded		
Kidney Diseases			AIDS or HIV Infection			Heart Trouble		
Liver Disease			STDs			Other		

9. Women Only:	YES	NO
Are you pregnant or think you may be pregnant?		
Are you nursing?		
Are you taking oral contraceptives?		

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signed
(Patient or Guardian): _____ Date: _____

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FINANCIAL POLICY

INSURED PATIENTS

This office is "in network" with the following *PPO Plans*: **Delta Dental**, **GEHA, Aetna, United Concordia, United Health Care, MetLife (PDP Plus, Fed VIP)**, **Guardian, Humana, Cigna, Dentemax**, **DentaQuest Choice PPO, Coalition of America PPO, Equitable, Mutual of Omaha, and Nationwide Insurance.**

As a courtesy, we will file all non-HMO insurances. Any remaining balance after the primary has paid will immediately become your responsibility.

Should the insurance pay more than the remaining balance, the difference shall be refunded to you by check or CC.

CO-PAY PAYMENT

All fees up to $100 may be required in full at the time of initial visit.

For all fees in excess of $100, you must pay your co-pay, as determined by this office, at the time of initial visit.

PAYMENT OF CO-PAY DOES NOT GUARANTEE THAT YOU HAVE PAID YOUR PATIENT PORTION IN FULL. AS A COURTESY WE WILL PROVIDE YOU WITH AN ESTIMATED CO-PAY. PLEASE BE ADVISED THAT THIS IS ONLY AN ESTIMATE. YOU ARE STILL RESPONSIBLE FOR ANY AMOUNTS WHICH ARE NOT COVERED BY YOUR INSURANCE. IF YOU NEED A COMPLETE BREAK-DOWN OF BENEFITS, PLEASE CONTACT YOUR INSURANCE COMPANY DIRECTLY.

UNINSURED PATIENTS and BCBS FEDERAL PATIENTS

All fees must be paid in full at the time of initial visit.

Fees in excess of $100 may be paid in two payments if treatment requires more than one visit.

If you are unable to pay with either of these options, we offer a payment plan or CareCredit financing. This program allows you to finance your dental treatment. Please ask the front desk personnel for additional information.

I have read and agree to adhere to the above financial policy.

Signed
(Patient or Guardian): _____ Date: _____
(SEAL)

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CONSENT TO ENDODONTIC THERAPY

Note: Please review the following consent. You are required to sign it prior to the initiation of treatment; however, it does not commit you to treatment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy. I agree to the use of local anesthesia, depending upon the judgment of the doctor(s). **Complications of root canal therapy and anesthesia may include swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum, or tongue, which rarely is protracted and even more rarely is permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately.**

I understand that root canal therapy is a procedure to retain a tooth, which may otherwise require extraction and that as a specialty practice, the office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require treatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling) and/or post and core, crown will be necessary to restore the tooth to function. I understand that I will be referred back to my general dentist to perform this restorative work. During treatment there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns, porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when my tooth may not be amenable to endodontic treatment at all. Other treatment choices include: no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in these choices might include but are not limited to pain, infection, swelling, loss of teeth and infection to other areas.

At times, medication will be prescribed by the endodontist. I understand that medications for discomfort and sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. I am advised against the use of alcohol or operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call this office immediately. I understand that it is my responsibility to report any changes in my medical history to the doctor(s).

If there is anything that you do not understand about the endodontic procedure, or any statement in this form, or if you still have any questions after reading this form and talking to the doctor, please write your questions below. If you have no questions, please write "NONE".

_____

_____

Signed
(Patient or Guardian): _____ Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, give Loudoun Endodontics, PLLC and their staff permission to discuss the following:

- Diagnosis, Prognosis, and/or Treatment Planning
- Test Results
- Scheduling Information
- Billing and/or Insurance Information

with appropriate parties from my Insurance Carrier, as well as other dental or medical practitioners, where deemed necessary by doctors or staff. **Initials** _____

I further authorize Loudoun Endodontics, PLLC and their staff to:

- Send email correspondence regarding my case to dental or medical practitioners **Initials** _____
- Leave messages on my home answering machine. **Initials** _____
- Leave messages on my work answering machine. **Initials** _____
- Leaves messages with my family and/or others residing in my household. **Initials** _____
- Discuss all aspects of my care (or my child's care, if minor) in this office with my spouse, significant other, or parents, as named below: **Initials** _____

_____

_____

I have been given ample time and opportunity to read the Notice of Privacy Practices, which has been made available to me for review. I understand that I may request a copy of the Notice of Privacy Practices at any time.

Signed
(Patient or Guardian): _____ Date: _____

NOTE: This form must be completed in order to ensure the confidentiality of our patients' medical/dental records. This authorization is valid for one year subsequent to the above date.